FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037168

Facility Name: FRANKLIN GROVE NURSING CTR

Address: 502 N. STATE STREET (Number) FRANKLIN GROVE (City) 61031 (Zip Code)

County: LEE

Telephone Number: (815) 456-2374 **Fax #** (815) 456-2381

IDPA ID Number: 363755778001

Date of Initial License for Current Owners: 06/28/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) NOSHIR R. DARUWALLA, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	70	Skilled (SNF)	70	25,550	1
2		Skilled Pediatric (SNF/PED)			2
3	51	Intermediate (ICF)	51	18,615	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	121	TOTALS	121	44,165	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,210	6,284	1,855	12,349	8
9	SNF/PED					9
10	ICF	14,104	12,921		27,025	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,314	19,205	1,855	39,374	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.15%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/1/91

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/1/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 1855

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	240,432	11,474	6,912	258,818		258,818		258,818			1
2	Food Purchase		188,580		188,580		188,580	(920)	187,660			2
3	Housekeeping	135,893	63,722		199,615		199,615		199,615			3
4	Laundry	81,431	22,071		103,502		103,502		103,502			4
5	Heat and Other Utilities			107,221	107,221		107,221	(412)	106,809			5
6	Maintenance	70,947	33,150	11,991	116,088		116,088	(923)	115,165			6
7	Other (specify):*											7
8	**TOTAL General Services**	528,703	318,997	126,124	973,824		973,824	(2,255)	971,569			8
	B. Health Care and Programs											
9	Medical Director			6,740	6,740		6,740		6,740			9
10	Nursing and Medical Records	1,156,053	8,009	2,322	1,166,384		1,166,384		1,166,384			10
10a	Therapy	55,447			55,447		55,447		55,447			10a
11	Activities	80,037	2,904		82,941		82,941		82,941			11
12	Social Services	22,841			22,841		22,841		22,841			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,314,378	10,913	9,062	1,334,353		1,334,353		1,334,353			16
	C. General Administration											
17	Administrative	98,407		180,000	278,407		278,407	(37,131)	241,276			17
18	Directors Fees											18
19	Professional Services			117,014	117,014		117,014	(81,541)	35,473			19
20	Dues, Fees, Subscriptions & Promotions			14,512	14,512		14,512	(6,162)	8,350			20
21	Clerical & General Office Expenses	177,444	3,515	55,380	236,339		236,339	36,901	273,240			21
22	Employee Benefits & Payroll Taxes			311,603	311,603		311,603		311,603			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,226	1,226		1,226	(235)	991			24
25	Other Admin. Staff Transportation			6,674	6,674		6,674	1,414	8,088			25
26	Insurance-Prop.Liab.Malpractice			24,763	24,763		24,763	1,827	26,590			26
27	Other (specify):*							11,797	11,797			27
28	**TOTAL General Administration**	275,851	3,515	711,172	990,538		990,538	(73,130)	917,408			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,118,932	333,425	846,358	3,298,715		3,298,715	(75,385)	3,223,330			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR #0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			36,052	36,052		36,052	58,876	94,928			30
31	Amortization of Pre-Op. & Org.							4,810	4,810			31
32	Interest			317	317		317	(317)	(0)			32
33	Real Estate Taxes			40,048	40,048		40,048	2,858	42,906			33
34	Rent-Facility & Grounds			397,485	397,485		397,485	(397,485)				34
35	Rent-Equipment & Vehicles							1,009	1,009			35
36	Other (specify):*							(276)	(276)			36
37	TOTAL Ownership			473,902	473,902		473,902	(330,525)	143,377			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		41,957	65,277	107,234		107,234	(262)	106,972			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,247	66,247		66,247		66,247			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		41,957	131,524	173,481		173,481	(262)	173,219			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,118,932	375,382	1,451,784	3,946,098		3,946,098	(406,172)	3,539,926			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,197)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	14,463	30		9
10	Interest and Other Investment Income	(75,361)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(920)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,300)	21		18
19	Entertainment				19
20	Contributions	(3,521)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,990)	21		24
25	Fund Raising, Advertising and Promotional	(275)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,282)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(5,621)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (91,004)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(315,168)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (315,168)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (406,172)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

FRANKLIN GROVE NURSING CTR

ID# 0037168

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	NON-CARE ASSET DEPREC EXPENSE	$ (108)	30	1
2	PAC DUES - IL COUNCIL	(2,425)	20	2
3	TRUST FEES	(250)	21	3
4	P/Y LEGAL EXP	(773)	19	4
5	RECLASS R&M	(1,760)	06	5
6	OUT OF PERIOD SEMINARS	(305)	24	6
7				7
8				8
9				9
10				10
11				11
12				12
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90				90
91				91

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(920)											(920)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(2,197)		1,785									(412)	5
6	Maintenance	(1,760)		837									(923)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(4,877)		2,622									(2,255)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative			(37,131)									(37,131)	17
18	Directors Fees													18
19	Professional Services	(773)		(91,450)	10,682								(81,541)	19
20	Fees, Subscriptions & Promotions	(6,221)		59									(6,162)	20
21	Clerical & General Office Expenses	(17,822)	3,074	51,649									36,901	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(305)		70									(235)	24
25	Other Admin. Staff Transportation			1,414									1,414	25
26	Insurance-Prop.Liab.Malpractice			1,827									1,827	26
27	Other (specify):*			11,797									11,797	27
28	**TOTAL General Administration**	(25,121)	3,074	(61,765)	10,682								(73,130)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(29,998)	3,074	(59,143)	10,682								(75,385)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	14,355	42,352	2,169									58,876	30
31	Amortization of Pre-Op. & Org.		4,810										4,810	31
32	Interest	(75,361)	20,386	2,291	52,367								(317)	32
33	Real Estate Taxes			2,858									2,858	33
34	Rent-Facility & Grounds		(397,485)										(397,485)	34
35	Rent-Equipment & Vehicles			1,009									1,009	35
36	Other (specify):*		(276)										(276)	36
37	TOTAL Ownership	(61,006)	(330,213)	8,327	52,367								(330,525)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(262)							(262)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers					(262)							(262)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(91,004)	(327,139)	(50,816)	63,049	(262)							(406,172)	45

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	32	INTEREST INCOME	$ 194,861	FRANKLIN GROVE ASSOCIATES		$	$ (194,861)	1
2	V	34	RENTAL INCOME	397,485	FRANKLIN GROVE ASSOCIATES			(397,485)	2
3	V	32	INTEREST EXPENSE		FRANKLIN GROVE ASSOCIATES		215,247	215,247	3
4	V	21	ACCOUNTING EXPENSE		FRANKLIN GROVE ASSOCIATES		3,074	3,074	4
5	V	30	DEPRECIATION EXPENSE		FRANKLIN GROVE ASSOCIATES		42,352	42,352	5
6	V	31	AMORTIZATION EXPENSE		FRANKLIN GROVE ASSOCIATES		4,810	4,810	6
7	V	36	GAIN ON PARTNERSHIP	276	FRANKLIN GROVE ASSOCIATES			(276)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 592,622			$ 265,483	$ * (327,139)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.W. MANAGEMENT	100.00%	$ 1,785	$ 1,785	15
16	V	6	REPAIRS AND MAINT.		S.W. MANAGEMENT	100.00%	837	837	16
17	V	19	PROFESSIONAL FEES		S.W. MANAGEMENT	100.00%	850	850	17
18	V	20	FEES, SUBSCRIPTIONS, DUES		S.W. MANAGEMENT	100.00%	59	59	18
19	V	21	CLERICAL AND GENERAL		S.W. MANAGEMENT	100.00%	51,649	51,649	19
20	V	24	EDUCATION AND SEMINARS		S.W. MANAGEMENT	100.00%	70	70	20
21	V	25	TRANSPORTATION		S.W. MANAGEMENT	100.00%	1,414	1,414	21
22	V	26	INSURANCE - PROPERTY		S.W. MANAGEMENT	100.00%	1,827	1,827	22
23	V	27	PAYROLL TAXES		S.W. MANAGEMENT	100.00%	9,012	9,012	23
24	V	30	DEPRECIATION		S.W. MANAGEMENT	100.00%	2,169	2,169	24
25	V	32	INTEREST EXPENSE		S.W. MANAGEMENT	100.00%	2,291	2,291	25
26	V	33	REAL ESTATE TAXES		S.W. MANAGEMENT	100.00%	2,858	2,858	26
27	V	35	AUTO LEASE		S.W. MANAGEMENT	100.00%	1,009	1,009	27
28	V								28
29	V								29
30	V	17	SALARY - SHELDON WOLFE		S.W. MANAGEMENT	100.00%	44,869	44,869	30
31	V	17	SALARY - RONNIE KLEIN		S.W. MANAGEMENT	100.00%	8,000	8,000	31
32	V	27	EMP. BEN.-SHELDON WOLFE		S.W. MANAGEMENT	100.00%	1,671	1,671	32
33	V	27	EMP. BEN.-RONNIE KLEIN		S.W. MANAGEMENT	100.00%	1,114	1,114	33
34	V								34
35	V	17	MANAGEMENT FEES	90,000	S.W. MANAGEMENT	100.00%		(90,000)	35
36	V	19	HOME OFFICE FEES	92,300	S.W. MANAGEMENT	100.00%		(92,300)	36
37	V								37
38	V								38
39	Total			$ 182,300			$ 131,484	$ * (50,816)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	SFO ASSOCIATES	100.00%	$ 10,682	$ 10,682	15
16	V	32	INTEREST		SFO ASSOCIATES	100.00%	241,930	241,930	16
17	V								17
18	V								18
19	V								19
20	V	32	INTEREST	189,563	SFO ASSOCIATES	100.00%		(189,563)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 189,563			$ 252,612	$ * 63,049	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SUPPLEMENTS	$	S & E MEDICAL SUPPLY	100.00%	$	$	15
16	V	39	ANICILLARY EXPENSE	1,308	S & E MEDICAL SUPPLY	100.00%	1,046	(262)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,308			$ 1,046	$ * (262)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING & MEDICAL SUPPLY	$ 5,026	PHARMCOR, L.L.C.	100.00%	$ 5,026	$	15
16	V	39	ANICILLARY EXPENSE	33,373	PHARMCOR, L.L.C.	100.00%	33,373		16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 38,399			$ 38,399	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	SHELDON WOLFE	OWNER	Administrative	31.74%	See Attached	4	7.00%	SW Mgmt	$ 44,869	17-7	1
2	RONNIE KLEIN	OWNER	Administrative	15.83%	See Attached	8	13.00%	SW Mgmt	8,000	17-7	2
3	RONNIE KLEIN	OWNER	Administrative	15.83%	See Attached	8	13.00%	Fees-facility	90,000	17-3	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 142,869		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.W. MANAGEMENT
Street Address: 7434 N. SKOKIE BLVD.
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAILABLE BED DAYS	450,410	8	$ 18,206	$	44,165	$ 1,785	1
2	6	REPAIRS AND MAINT.	AVAILABLE BED DAYS	450,410	8	8,532		44,165	837	2
3	19	PROFESSIONAL FEES	AVAILABLE BED DAYS	450,410	8	8,672		44,165	850	3
4	20	FEES, SUBSCRIPTIONS, DUES	AVAILABLE BED DAYS	450,410	8	603		44,165	59	4
5	21	CLERICAL AND GENERAL	AVAILABLE BED DAYS	450,410	8	526,738	470,813	44,165	51,649	5
6	24	EDUCATION AND SEMINARS	AVAILABLE BED DAYS	450,410	8	710		44,165	70	6
7	25	TRANSPORTATION	AVAILABLE BED DAYS	450,410	8	14,421		44,165	1,414	7
8	26	INSURANCE - PROPERTY	AVAILABLE BED DAYS	450,410	8	18,629		44,165	1,827	8
9	27	PAYROLL TAXES	AVAILABLE BED DAYS	450,410	8	91,903		44,165	9,012	9
10	30	DEPRECIATION	AVAILABLE BED DAYS	450,410	8	22,118		44,165	2,169	10
11	32	INTEREST EXPENSE	AVAILABLE BED DAYS	450,410	8	23,361		44,165	2,291	11
12	33	REAL ESTATE TAXES	AVAILABLE BED DAYS	450,410	8	29,144		44,165	2,858	12
13	35	AUTO LEASE	AVAILABLE BED DAYS	450,410	8	10,285		44,165	1,009	13
14										14
15										15
16	17	SALARY - SHELDON WOLFE	AVG. HOURS WORKED	60	9	673,036	673,036	4	44,869	16
17	17	SALARY - RONNIE KLEIN	AVG. HOURS WORKED	60	7	60,000	60,000	8	8,000	17
18	27	EMP. BEN.-SHELDON WOLFE	AVG. HOURS WORKED	60	9	25,062		4	1,671	18
19	27	EMP. BEN.-RONNIE KLEIN	AVG. HOURS WORKED	60	7	8,356		8	1,114	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,539,776	$ 1,203,849		$ 131,484	25

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SFO ASSOCIATES
Street Address: 7434 N. SKOKIE BLVD.
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	NOTE RECEIVABLE	6,500,000	3	$ 24,796	$	2,800,000	$ 10,682	1
2	32	INTEREST	NOTE RECEIVABLE	6,500,000	3	561,623		2,800,000	241,930	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 586,419	$		$ 252,612	25

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S & E MEDICAL SUPPLY
Street Address: 3100 COMMERCIAL AVENUE
City / State / Zip Code: NORTHBROOK, ILLINOIS 60062
Phone Number: (847) 982-9300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SUPPLEMENTS	DIRECT ALLOCATION			$	$		$	1
2	39	ANICILLARY EXPENSE	DIRECT ALLOCATION						1,046	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 1,046	25

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PHARMCOR, L.L.C.
Street Address: 3116 S. OAK PARK
City / State / Zip Code: BERWYN, IL 60402
Phone Number: (708)795-7701
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING & MEDICAL SUPPLY	DIRECT ALLOCATION			$	$		$ 5,026	1
2	39	ANICILLARY EXPENSE	DIRECT ALLOCATION						33,373	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 38,399	25

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
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15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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14										14
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	alloc. Franklin Grove Assoc	X					$	$ 2,153,846			$ 189,563	1
2	loan payable SFO											2
3												3
4												4
5												5
	Working Capital											
6	note payable insurance		X								317	6
7												7
8												8
9	TOTAL Facility Related						$	$ 2,153,846			$ 189,880	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(189,881)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (189,881)	14
15	TOTALS (line 9+line14)						$	$ 2,153,846			$ (1)	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income - Facility	X					$	$			$ (75,361)	1
2												2
3	alloc: Franklin Grove Assoc	X										3
4	Interest income										(194,861)	4
5	Interest Exp - Non-SFO										25,684	5
6												6
7												7
8												8
9	Allocation SW Mgmt	X									2,290	9
10												10
11	Allocation SFO	X										11
12	Interest income										(189,563)	12
13	Interest Expense										241,930	13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (189,881)	21

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 41,066	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 42,425	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,359	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 41,546	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 42,905	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	36,816	8
	1997	38,353	9
	1998	38,480	10
	1999	39,110	11
	2000	39,567	12

R.E. TAX ACCRUAL 2001:
39,567 X 1.05 = 41,546
allocation from SW Mgmt = 2858

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FRANKLIN GROVE NURSING CTR COUNTY LEE

FACILITY IDPH LICENSE NUMBER 0037168

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1166

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-03-36-351-007	Nursing Facility	$ 39,567.36	$ 39,567.36
2.	See Attached	Allocated from SW Mgmt	$ 30,227.00	$ 2,858.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 69,794.36	$ 42,425.36

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,868 B. General Construction Type: Exterior BRICK Frame CONCRETE& STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

ASSISTED LIVING 45 UNITS

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 150,339
2. Number of Years Over Which it is Being Amortized: 30
3. Current Period Amortization: 4,810
4. Dates Incurred: AUGUST 1994

Nature of Costs: SW MANAGEMENT ALLOCATION
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1991	$ 36,205	1
2					2
3	TOTALS			$ 36,205	3

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1991	6,395	203	20	320	117	3,227	9
10	Various			1992	29,415	1,737	20	1,471	(266)	14,097	10
11	Various			1993	47,512	-	20	2,376	2,376	21,976	11
12	Various			1994	17,652	297	20	883	(586)	6,822	12
13	Various			1995	10,809	164	20	541	377	3,570	13
14	Various			1997	55,791	3,433	20	2,792	(641)	14,284	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		1,386,066	43,834		39,873	(3,961)	410,999	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 1,553,640	$ 49,668		$ 48,256	$ (2,584)	$ 474,975	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,553,640	$ 49,668		$ 48,256	$ (1,412)	$ 474,975	1
2	NEW GENERATOR	1998	65,000	1,667	20	3,250	1,583	9,070	2
3	DOORS WITH PLASTIC	1998	11,052	283	20	553	270	1,448	3
4	DOOR WITH PLASTIC	1998	9,760	250	20	488	238	1,278	4
5	RETROAIRE CLASSIC	1998	2,152	248	20	108	(140)	755	5
6	CIRCUIT BREAKER	1999	21,000	538	20	1,050	512	2,538	6
7	AIR CONDITIONERS	1999	807		20	40	40	103	7
8	RETROAIRE CHASSIS	1999	2,306		20	115	115	297	8
9	RETROAICE CHASSIS	2000	2,321		20	116	116	116	9
10	KITCHEN LABOR	2001	3,163	3,163	20	26	(3,137)	26	10
11	KITCHEN LABOR	2001	1,532	1,532	20	13	(1,519)	13	11
12	WATER MAIN LINE	2001	3,294	60	20	124	64	124	12
13	WALK IN FREEZER	2001	8,947	8,947		186	(8,761)	186	13
14	WIRING TO KITCHEN	2001	12,250	8,234		460	(7,774)	460	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,697,224	$ 74,590		$ 54,785	$ (19,805)	$ 491,389	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,697,224	$ 74,590		$ 54,785	$ (19,805)	$ 491,389	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,697,224	$ 74,590		$ 54,785	$ (19,805)	$ 491,389	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,697,224	$ 74,590		$ 54,785	$ (19,805)	$ 491,389	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,697,224	$ 74,590		$ 54,785	$ (19,805)	$ 491,389	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 1,697,224	$ 74,590		$ 54,785	$ (19,805)	$ 491,389	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,697,224	$ 74,590		$ 54,785	$ (19,805)	$ 491,389	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 1,697,224	$ 74,590		$ 54,785	$ (19,805)	$ 491,389	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,697,224	$ 74,590		$ 54,785	$ (19,805)	$ 491,389	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 1,697,224	$ 74,590		$ 54,785	$ (19,805)	$ 491,389	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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10									10
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,697,224	$ 74,590		$ 54,785	$ (19,805)	$ 491,389	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 1,697,224	$ 74,590		$ 54,785	$ (19,805)	$ 491,389	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,697,224	$ 74,590		$ 54,785	$ (19,805)	$ 491,389	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 1,697,224	$ 74,590		$ 54,785	$ (19,805)	$ 491,389	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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17									17
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,697,224	$ 74,590		$ 54,785	$ (19,805)	$ 491,389	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	121		1991		$ 1,334,100	$ 42,352	35	$ 38,117	$ (4,235)	$ 400,229	4
5	SW Mgmt		1995		42,547	1,091	35	1,216	125	8,090	5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated SW Mgmt			1995	4,528	234	20	270	36	1,738	9
10	Allocated SW Mgmt			1996	791	20	20	40	20	220	10
11	Allocated SW Mgmt			1997	1,139	61	20	82	21	348	11
12	Allocated SW Mgmt			1998	784	20	20	39	(19)	147	12
13	Allocated SW Mgmt			1999	2,177	56	20	109	53	227	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,386,066	$ 43,834		$ 39,873	$ (3,999)	$ 410,999	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 519,032	$ 2,135	$ 39,741	$ 37,606	10	$ 450,445	71
72	Current Year Purchases	5,926	3,740	402	(3,338)	10	402	72
73	Fully Depreciated Assets	1,745					1,745	73
74								74
75	TOTALS	$ 526,703	$ 5,875	$ 40,143	$ 34,268		$ 452,592	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	2,260,132	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	80,465	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	94,928	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	14,463	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	943,981	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	BILL NIGUE - 1995	$ 4,200	$ 108	$ 706	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 4,200	$ 108	$ 706	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ALLOC SW MGMT		$	$ 1,008	17
18					18
19					19
20					20
21	TOTAL		$	$ 1,008	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 24,383	$		$ 24,383	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			1,126			1,126	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			39,768			39,768	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				36,856		36,856	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						5,101		5,101	13
14	TOTAL			$		$ 65,277	$ 41,957		$ 107,234	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 643,385	$ 645,385	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	472,275	472,275	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	61,156	61,156	6
7	Other Prepaid Expenses	2,335	2,335	7
8	Accounts Receivable (owners or related parties)	1,191,279	3,435,683	8
9	Other(specify): See supplemental schedule	268,169	268,169	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,638,599	$ 4,885,003	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		36,205	13
14	Buildings, at Historical Cost		1,334,101	14
15	Leasehold Improvements, at Historical Cost	198,433	198,433	15
16	Equipment, at Historical Cost	470,222	641,222	16
17	Accumulated Depreciation (book methods)	(502,678)	(1,116,609)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		108,131	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	6,600	6,600	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 172,577	$ 1,208,083	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,811,176	$ 6,093,086	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 165,391	$ 165,391	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	53,154	53,154	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,844	5,844	31
32	Accrued Real Estate Taxes(Sch.IX-B)	41,546	41,546	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 265,935	$ 265,935	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		2,153,846	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,153,846	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 265,935	$ 2,419,781	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,545,241	$ 3,673,305	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,811,176	$ 6,093,086	48

*(See instructions.)

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,197,567	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,197,567	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	831,674	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(484,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 347,674	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,545,241	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,586,491	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,586,491	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	44,155	6
7	Oxygen	5,480	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 49,635	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,487	19
20	Radiology and X-Ray		20
21	Other Medical Services	1,563	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 22,050	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	119,095	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 119,095	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	501	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 501	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,777,772	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	973,824	31
32	Health Care	1,334,353	32
33	General Administration	990,538	33
	B. Capital Expense		
34	Ownership	473,902	34
	C. Ancillary Expense		
35	Special Cost Centers	107,234	35
36	Provider Participation Fee	66,247	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,946,098	40
41	**Income before Income Taxes (line 30 minus line 40)****	831,674	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 831,674	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Cash basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,960	2,080	$ 45,640	$ 21.94	1
2	Assistant Director of Nursing	2,000	2,080	38,940	18.72	2
3	Registered Nurses	5,253	5,454	100,799	18.48	3
4	Licensed Practical Nurses	18,335	19,069	327,115	17.15	4
5	Nurse Aides & Orderlies	62,553	64,237	643,559	10.02	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,326	5,610	55,447	9.88	8
9	Activity Director					9
10	Activity Assistants	6,950	7,195	80,037	11.12	10
11	Social Service Workers	1,934	1,994	22,841	11.45	11
12	Dietician					12
13	Food Service Supervisor	4,887	5,071	69,927	13.79	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,654	23,556	170,505	7.24	15
16	Dishwashers					16
17	Maintenance Workers	5,747	6,058	70,947	11.71	17
18	Housekeepers	18,217	19,346	135,893	7.02	18
19	Laundry	10,174	10,812	81,431	7.53	19
20	Administrator	1,921	2,080	98,407	47.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,205	11,892	177,444	14.92	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	179,116	186,534	$ 2,118,932 *	$ 11.36	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	115	$ 6,912	01-03	35
36	Medical Director	104	6,740	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	2,322	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	267	$ 15,974		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	none			51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JILL GEE	Administrator		$ 98,407
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 98,407

B. Administrative - Other

Description	Amount
SW MANAGEMENT	$ 90,000
RONNIE KLEIN	90,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 180,000

C. Professional Services

Vendor/Payee	Type	Amount
Winston & Strawn	Legal	$ 2,274
Frost, Ruttenberg & Rothblatt	Accounting	22,440
SW Management	Home Office Costs	92,300
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 117,014

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 44,010
Unemployment Compensation Insurance	14,236
FICA Taxes	160,979
Employee Health Insurance	86,301
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	300
Holiday Expense	5,777
TOTAL (agree to Schedule V, line 22, col.8)	$ 311,603

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	3,270
Health Care Worker Background Check	720
(Indicate # of checks performed 60)	
Licenses	400
Illinois Council on LTC	3,611
Dues & Subcriptions	90
Promotional Advertising	275
Allocation SW Mgmt	59
Less: Public Relations Expense	
Non-allowable advertising	(275)
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,350

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	921
Allocation SW Mgmt	70
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 991

**See instructions.

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	none		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number FRANKLIN GROVE NURSING CTR # 0037168 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ICLTC - $6,036

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ NONE Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 66,247
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? NONE
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees